JOINT STANDING COMMITTEE ON THE COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

INQUIRY INTO THE MONITORING AND ENFORCING OF CHILD SAFE STANDARDS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 28 MARCH 2019

SESSION ONE

Members

Hon Dr Sally Talbot, MLC (Chair)
Mr K.M. O'Donnell, MLA (Deputy Chair)
Hon Donna Faragher, MLC
Mrs J.M.C. Stojkovski, MLA

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Hearing commenced at 1.02 pm

Ms DEBORA COLVIN
Chief Mental Health Advocate, Mental Health Advocacy Service, examined:

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the Joint Standing Committee on the Commissioner for Children and Young People. My name is Dr Sally Talbot; I am the Chair of the committee. I will let my colleagues introduce themselves.

Hon DONNA FARAGHER: I am Donna Faragher, member for the East Metro Region.

Mr K.M. O'DONNELL: Kyran O'Donnell, member for Kalgoorlie.

Mrs J.M.C. STOJKOVSKI: Jessica Stojkovski, member for Kingsley.

The CHAIR: Kyran is my Deputy Chair. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you might say outside of today's proceedings.

Before we begin, do you have any questions about your attendance here today?

Ms Colvin: No, I do not think so.

The CHAIR: Would you like to make any kind of opening statement?

Ms Colvin: No, I have not prepared anything. There are things I can talk about, but I have prepared on the basis of the questions you asked in the letter.

The CHAIR: Okay. If we start working our way through there, we will keep the structure of what we are doing fairly informal.

You are aware of what our inquiry is about—our terms of reference. There is a bit of a history to this inquiry, which I am sure you are familiar with. The chief reason you are here today—perhaps the reason this is your first appearance before this committee—is that when the Commissioner for Children and Young People prepared his oversight report in 2017, he made reference to your agency as one of the oversight bodies with responsibility for services that deliver to children and young people.

Ms Colvin: Yes, I am aware of that report.

The CHAIR: We have taken that report as one of our stepping-off points. We are interested to see how the report was received, what comments you have about the report, and how you regard the recommendations from the report. Given the nature of the commissioner's office and that he does not have enforcement powers, it is not a report that attracts a direct response from the state. That is the general tenor of what we are talking about today. Of course, the commissioner's report comes at an interesting time. We have had the Blaxell inquiry, the commissioner's report, and the findings of the royal commission, so there is a general widespread state government–wide interest in the issues of child protection and child-safe organisations. This committee is particularly interested in the oversight functions, so that is where we are coming from. Your agency clearly has a role to play in all that, given that you are one of the agencies that the commissioner identifies.

Ms Colvin: Yes, and I would agree with that.

The CHAIR: I will start by reminding you—because I am sure you know them—of those Australian Law Reform Commission parameters for oversight bodies, just to get your comments about your organisation and how it fits into those eight dot points.

Ms Colvin: Yes, I did see those. I must be honest, I was not familiar with them. One of the things that I would say about that is the way it focused a lot on investigation, I suppose. Remember, we are, as the name suggests, an advocacy body as well as that. In terms of oversight bodies, I guess ours is perhaps a bit unusual, because it does both individual and systemic advocacy, which I think is a big plus. We can talk about that later.

I did go through the parameters. I think what you were interested in was how we measured ourselves against those. Is that what you would like me to do now, or maybe chat a bit more about our jurisdiction?

The CHAIR: These are obviously very broad, high-level parameters. What we are interested in, firstly, is seeing whether your reaction to those is, "Well, we do some of them but not others." Then we would be interested in following up the ones that do not fit within your organisation.

Ms Colvin: The first headings that I have are "statutory independence" and "adequate resources". Would you like me to go through those?

The CHAIR: Yes, just work through them.

Ms Colvin: I can certainly do that. In terms of statutory independence, you may be aware that under the Mental Health Act, the position of the Chief Mental Health Advocate is appointed by the Minister for Mental Health. At the time, we did argue to be appointed by the Governor. Both the Chief Psychiatrist and the president of the Mental Health Tribunal that are also established underneath that act are appointed by the Governor, and you are probably already aware that the Inspector of Custodial Services, who deals with prisons, is appointed by the Governor. Everybody says that it makes you more independent if you are appointed by the Governor. Personally, I am not entirely convinced of that in practice, because I understand that in practice, to get on to the agenda for the Governor to even make a decision, it goes via a minister, and so on, so I am not entirely convinced that that makes it any more independent, but I point that out to you, because this entity is not appointed by the Governor. When we had discussions about the optional protocol against torture, for example, that is one of the things that they discuss in there as well.

We have very similar legislation to, again, the Inspector of Custodial Services. I should have looked this up; I am not sure about the Commissioner for Children and Young People: the minister is allowed to give some directions in consultation with the Chief Mental Health Advocate, but they are not about individuals, and that sort of thing. So the legislation in all those agencies is pretty similar in that sense. To fill you in on that, the only time there has been a direction by the minister was at my request, and that was in terms of voluntary children. In terms of statutory independence, therefore, it is probably as good as any out there, other than that one point.

The CHAIR: Is there a distinction in your reporting mechanism?

Ms Colvin: Yes, there is, in that the Inspector of Custodial Services puts all his reports in to Parliament, whereas my reports go to the minister. I only have to do an annual report; it has to go to the minister and the minister has to put it in to Parliament. It is exactly the same under the Declared Places (Mentally Impaired Accused) Act, which I am also the chief advocate for. The minister has no choice but to put it in to Parliament. If you are asking me whether the minister can come back to me and say that they do not like what is in the annual report, it has never happened, and I do not know what would happen if it did. I would refuse to change it, unless, of course, it was some obvious mistake, or something like that. I have no problem with errors being fixed up. In that

sense, our annual report goes into Parliament, and it certainly has been considered over the years. Prior to being the Chief Mental Health Advocate, I was the head of the Council of Official Visitors, and it was a similar process.

[1.10 pm]

The CHAIR: Okay. The second dot point is adequate resources.

Ms Colvin: If you read my annual report, you will see a lot of discussion about that. We were never funded properly from the beginning. I cannot tell you all the reasons for that. We continue not to be funded. We continue to put in submissions to Treasury about that. What happens as a result of that? A number of functions under the act are what you might call discretionary—for example, investigations. We have quite a strong power in there to inquire into and investigate conditions that might adversely impact the safety and welfare of—we all call them consumers—identified persons, as they are under the act. Obviously, it includes children. But it is constrained by resources. It does not say that we have to do it for every facility. It does not say how often we have to do it or anything like that. Ultimately, you have got a discretion, whereas other things we do not have discretion about. Under the act, we must make contact with every person who is made involuntary—if they are an adult, within seven days; and if they are a child, within 24 hours. That is a must, so your focus goes on that. The workload of that is huge and it has grown since we started. There are a number of potential reasons for that as well. Most of the money goes into that work.

The CHAIR: Do you have adequate resources to do that? Are you able to fulfil that statutory function?

Ms Colvin: We have struggled. Again, a lot of it is about managing your finances. For example, the other issue with the act is that the advocates have to be engaged by the Chief Mental Health Advocate under a contract for services. As part of that, they are like independent contractors. We had to take State Solicitor's advice about all of that sort of thing, but what it means is that, in essence, the way we have it, they are paid on an hourly basis, so you are constantly conscious of the time they are spending doing things and you have to try to manage all of this. It means, also, that they do not get any leave, for example. They can just come to you and say, "I'm not available for the next three months because I've decide I'm taking time off." You get hit with those sorts of management-type issues. That can affect us. We also try to keep the numbers as lean as possible because we do do training and we do have team meetings. Of course, the more people you have, the more you have to pay for that.

The CHAIR: How many advocates do you have?

Ms Colvin: It varies a bit. It is around the 33 or 34 mark. We are actually recruiting at the moment because I am just at the point where we cannot cope anymore. What happens is that advocates become unwell or they have other commitments. It is a very difficult job for them because although they are what you might call part-time, you cannot say as an advocate how much work you are going to get in a week. Some of the advocates were close to full-time but when you get allocated to a consumer, you do not know how much time you are going to have to spend with the consumer. We are constantly juggling workloads in that way. You can get runs. We have tried to sort of predict this, but it is really hard to predict the way in which the orders come in. It goes up and down like that. You run into a whole load of management issues around that. As I say, we have tried to keep it fairly lean and mean, but we are doing a major recruitment at the moment. Youth advocates is another area where—the act says we have to have a youth advocate. We have currently —

The CHAIR: The act says "one", does it not—or at least one?

Ms Colvin: It actually says "a". It says "at least one" or something like that. I have got two. I am looking for a third. But one of my youth advocates is out of action. She was basically full-time. There are personal reasons that she is out of action. It just completely throws you. I am sure lots of other people managing teams of people have these issues. There are a few little things in there that are made tricky for us. In terms of do we have enough people, all the effort goes into meeting those statutory requirements. Yes, we do it. What we do is we pull in other advocates to do extra work. Sometimes—I have two senior advocates—we will end up doing things. You make it work, that sort of thing, if that is an answer to your question.

We have also just gone through an office restructure, for which we have been waiting for a long time. You are probably not interested in all these details. It takes time. What happens with the notifications to us, because we have to be notified by health services when people are made involuntary, initially, it was all by fax and email and there were a whole load of issues around that. Eventually, they put the orders that make people involuntary on their database, which is called PSOLIS. Eventually, we got a bit of access to it and then we had to build a bridge to get it into our database—you go through all of this. We are just at that point now. It is nearly three and a half years in, but things take time.

The CHAIR: I do not think you would be the only agency suffering from that sort of thing.

Ms Colvin: No, and the Mental Health Tribunal is in a lot worse position than us in that sphere as well.

The CHAIR: The committee is interested in all of this. Do not feel that we are not. I guess what you are saying is that you have adequate resources, just about, to cover your statutory functions, but were you going to go on to say that —

Ms Colvin: I correct you there. I do not think we are covering our statutory functions. This is what I have told the minister and I have told Treasury. To the extent that some of our functions are discretionary and therefore you do not have to do them, you might say that. But I think we should be doing a lot more, particularly in terms of the inspection and investigation space.

The CHAIR: That brings us to investigative powers, which is the third dot point.

Ms Colvin: We are pretty good on that in terms of what the act gives us. The one thing that we would prefer to have changed—and I did argue for this back when they were drafting the new act—is that for us to see medical files, if the person is involuntary, the act uses interesting terminology which talks about that the person has not objected to seeing the file. If the person is voluntary, it has to be consent, and consent raises issues to do with capacity, and there are some other provisions. Not objecting does not take much, but it limits us, for example, in comparison to the Chief Psychiatrist, who can just go in and look at anything he likes. We are limited to that extent. As a result, there are also other areas where we might want to ask more questions and more things and we get hit by, "Well, you need consumer consent"—that sort of thing. There are some limits there. It is also relevant if we become one of the agencies working under the OPCAT—the Optional Protocol to the Convention against Torture—provisions as well.

The CHAIR: What about the spread of institutions that you have access to?

Ms Colvin: The spread is all authorised hospitals, which is basically your inpatient mental health services. It also goes across into EDs and general hospitals now, under the new act. There are some issues around that and there are some legal issues which remain unanswered and which we have not delved into. But, certainly, we are in EDs a lot increasingly. Anybody who is on what is called a form 6B who is on an involuntary order in a general ward, we can also go and see them and so on.

As to quite how much further you would go about the conditions on that ward, under the act, it remains to be seen.

[1.20 pm]

That is in your inpatient space. It does not include, for example, the likes of Perth Clinic and private hospitals like Hollywood. It does not include—well, for example, Royal Perth has a mental health ward, which is not authorised, although they are working on getting one. Therefore, to that extent, we can see a person if they are on an involuntary order on that ward, which is really not happening because they are more likely to go into a general ward or somewhere else. Then, in terms of mental health services in the community, we are pretty much limited to those which are defined as psychiatric hostels. This is a definition which everybody seems to agree needs amending, but it is under different legislation, which is designated for review but is currently on hold, I understand; and, that is, the Private Hospitals and Health Services Act. That definition does limit it to places where people—and one of the key words is "reside", which means that it is like a home. So short-term, short-stay places like the step up, step downs are not included. It comes under licensing; it has a lot to do with licensing and our act picks up on the same definitions. So the new step up, step downs, we are not involved in. There are a number of places that people are discharged to, which are not really mental health services anyway, frankly, but there is a place we all call "Tate Street", out Bentley way somewhere, which people tell us is a terrible place: "Why is it not licensed? It's full of mental health patients." But we cannot go there; it is not within our jurisdiction.

The CHAIR: Do you think you should be able to go there?

Ms Colvin: Some of my advocates would definitely think that. It is an interesting thing, because as far as I know it has no government funding or anything like that; it is just a boarding house. The real issue, probably more at the other end, is that we do not have enough supported accommodation to send people to, and so our mental health services are sending people to those places out of desperation. That is really the issue rather than anything else.

The CHAIR: The Kath French centre?

Ms Colvin: Kath French centre, yes. The Kath French centre is definitely a place that we cannot go to, and when that legislation came in, I and the Inspector of Custodial Services and a couple of other people did raise issues about that because there is no independent advocacy in there, there is no oversight at all. I have raised that over and over again. I have actually pushed in submissions I have made to do with OPCAT, that it needs to be covered and so on; so, yes, definitely. Prisons is another area where the Inspector of Custodial Services is in. Technically, if a person is on a referral order, a 1A—this is where an authorised mental health practitioner has decided that they might fit the criteria for being made involuntary, which in essence means inpatient care—and because we are talking about youth, let us focus on Banksia Hill Detention Centre. In theory, if they are on a 1A, we can assist them, but the way the act is worded, they have to request our assistance. The act also requires that they be told their rights.

The CHAIR: Can you just tell us what a 1A is?

Ms Colvin: Yes, sorry. It is the start of the journey to being made involuntary. We tend to talk in numbers because it is the different forms, but it is the referral process. It is section 26 in the act. If an authorised mental health practitioner, or any doctor, any medical practitioner—not a psychiatrist—thinks there is a reasonable prospect that the person meets the criteria of the act for being made involuntary in section 25, they can order the person to be examined by a psychiatrist. I suppose the real answer to your question is that it is a compulsory examination by a psychiatrist. In emergency departments and, frankly, probably out in the community in the community mental

health services, it usually goes hand in hand with a form 3, which is another power under the act to detain the person until they get that examination. In prison, of course, they do not do the form 3s because they are detained anyway. You may have read—I do not know if you have spoken to the Inspector of Custodial Services—but there has been a major issue with all people in prisons getting into inpatient care.

In terms of the children, I guess for us they have to request assistance—nobody is requesting assistance, frankly, even in the adult prisons let alone the kids prison. But where we started to get involved was when we had a couple of children, 17-year-olds, put into the Frankland Centre, which is the forensic service. We were outraged. That led to asking questions. I did call a meeting with the Inspector of Custodial Services and the commissioner for children, and in the end, to be honest with you, I got frustrated, so I called for a meeting. In fact, I wrote to the director general of corrective services—actually, it was justice by then, and to the two health service providers to do with the two youth wards. At that stage I was leaving out child and adolescent services because they were still taking younger kids in. It was our 16s and 17s, so we had our two youth wards being the one at Bentley—the East Metropolitan Youth Unit; we call it EMYU—and the Fiona Stanley one. They were not taking kids from Banksia Hill. So we asked for a meeting. It was held out at Banksia Hill Detention Centre. We had a bunch of corrective services people there, we had people from Fiona Stanley and from EMYU, Bentley. We also got people in from Frankland as the forensic experts; the Chief Psychiatrist came along. That was when we first started to sort of do more work in this space.

Out of that—it is interesting the way things work because a lot of it was about communication: what the Banksia Hill people did not understand about the problems for the mental health wards, what the mental health ward people did not understand about what was happening out in the prison, in particular where they were keeping the kids. That was another situation we had, where a young girl had been kept in isolation for basically a month, waiting for a bed. In fact, Frankland had taken her in, basically, just to give her a break, and so on. That piece of work led to both those youth wards taking children now, some connections between them all, and there is some pathways work going on in the bigger picture, sort of thing. To that extent, we are now getting more youth from detention, as in Banksia Hill, coming into those wards.

There have been ongoing issues. The next thing we have done in that space—because we had a situation with a young man who was in Fiona Stanley. He was on bail at that stage to a family member. The family member withdrew bail, so all of a sudden he is still in Fiona Stanley, but we have Banksia Hill custodial service officers turning up and we had a big clash and the child landed up back in Banksia Hill. It was just outrageous really. That led to some more work that we are doing where—again I went back to corrective services and had a meeting with them. At that stage, in fact, there were two children in EMYU and four custodial service officers in EMYU with them, which is just a terrible thing to have happened for all the other patients that are there as well. Corrective Services, in fact, told me that they had to do an extra lockdown back at the prison because they had to send four custodial services officers to EMYU. They were definitely keen. I said, "What's it going to take? Why have we got this situation?" Basically, they needed to do a risk assessment so that they could then issue operational orders, which then allowed them to send fewer custodial service officers. They are underway, doing that. It is not finalised yet, but the news is looking very good that they might have to send only one, that they might be able to stay in the nurses' centre if they can get a few more CCTV cameras, so they can meet their legislation and so on. Then after they have done EMYU, they will move to Fiona Stanley. To that extent we have some involvement with children from Banksia Hill.

The CHAIR: Are there any questions from my colleagues?

Mrs J.M.C. STOJKOVSKI: My only question is: how would they know to ask for you?

Ms Colvin: Sorry, I think I took myself slightly off track there. The act says that they are supposed to be given information about their rights, but we do not know what information they are given. This is true even in EDs. We had some early meetings with Corrective Services about some of that and it might be something that I might do more work on later on, to make sure that they are being told that they can contact us. I cannot really answer that; I do not really know how practical that is.

The CHAIR: Are there different provisions for children and young people to adults, or is it the same provisions for both?

Ms Colvin: No, it is exactly the same provisions. To be honest, to really get it to work in terms of requests, particularly to do with children, you really need to be on site. It is the same in the hostel space, particularly if you are not well, to sort of take that in and know to pick up the phone or ask. They would have to ask. My understanding of prisons—I am a bit limited and have only been learning because of these recent initiatives we have taken—is that to make a call, you have to have a certain number approved and there are things like that that go on.

Mrs J.M.C. STOJKOVSKI: My concern about that is if they are suffering under a mental health condition, how are they going to then know —

Ms Colvin: One of the reasons I have probably not pushed it is because it is limited on what we can actually do. I can get a call on a 1A if they are in prison, and if there are no beds, there are no beds. Particularly with adults, because they can only go into Frankland. That is another space we have been exploring. We have supported the work done by the Inspector of Custodial Services on that area. For children, I think we really have to get it sorted out—this pathway through—first. That is actually probably the better work that we can do. It is hard to know what you can do.

The CHAIR: Are these the involuntary patients, or is this any child who becomes a mental health patient?

Ms Colvin: At the moment I am talking about anyone who is on a 1A, which means that they have been referred for mandatory examination by a psychiatrist. I was referring to the people in prison. If they are in emergency departments—we were working with a number of them yesterday and today. I will give you an example of the sort of work we can do in that space. This was an example in which we were aware of a child who, by the time we got him moved on, it had been about 92 or 96 hours he had been in ED. He was really, really unwell. There were no other options for him, other than an inpatient ward. He was in a north metro ED. His catchment area—in other words, the ward he was supposed to go to, particularly if he is east—is EMYU. EMYU had no beds. We had two other people in another north metro hospital also designated to be made involuntary, looking very unwell, on 1As. Because we have good relationships, because the youth advocates know things, we ended up speaking to somebody at EMYU; in fact, it was higher than EMYU. They said, "We've got three kids: how do we choose between the three of them?" There is one there and two in the other; one of those boys, they understood at the time, was on four-point restraints. Where we got involved was we were involved with all three children. You have the really unwell one at this hospital over there, you have the two up there. The boy is no longer on four-point restraints and he is in a lot better space. The girl who was there had her father with her and she was terrified of going to EMYU because she had been there when it was Bentley Adolescent Unit and she just desperately did not want to go there; she found it all too traumatic. So basically, having spoken to them and got their input on things, we can feed that through to the person making the decision for east metro. So, in essence, the boy over here went there first when the first bed came up, the second boy went there, and the girl negotiated to get into Fiona Stanley. That is how we get involved in the 1A space with the kids. It is about finding out.

I will give another example. A child in Charlie Gairdner ED, where we are doing a lot of work at the moment, had been waiting—I cannot remember how many hours; too many hours. We got called by the doctor, because doctors can call us and we have done some work with them. They are now calling us quite regularly with these cases, because they are so frustrated with people being stuck in the ED. Having talked to this particular young person and their family, they ended up going into hospital in the home—HITH. In other words, they went home with care coming in, which did not seem to have been considered, or, if it had, they had all said no to it and so on. That is the sort of space you do with the referral 1A section.

The CHAIR: Okay. We are now on our third dot point! I think we could have spent the entire hour just on the dot points.

Ms Colvin: Is that the investigative powers?

The CHAIR: That is the investigative powers, yes. I am interested in your comments on this—active participation by children—but I think you probably covered that in terms of —

Ms Colvin: We think we could do more. I think some of that is around—we do not have any sort of consumer committees working with us, if you know what I mean, so to that extent we could do more. In terms of active participation by children in the process when they are being made involuntary, no, our entire approach is based on the child.

The CHAIR: What is your relationship like with the other oversight bodies in mental health care and advocacy for children and young people? For instance, the Commissioner for Children and Young People—what sort of contact would you have, and what is the relationship between that agency and you like?

Ms Colvin: I think it is improving, actually. I confess to in the past having been a bit frustrated. In fact, I have a meeting tomorrow with him and the Inspector of Custodial Services, and it is about sharing information, really, and issues of concern to each other. As I said, I also got him involved when we were looking at the issues with Banksia Hill Detention Centre. I think they are doing more in that space now, too. Similarly, one of my senior advocates meets with the person in his office who is designated to mental health, so again, it is a lot about sharing information. We have the advantage of the stories, if you like, because we are dealing with the individual advocacy, and that was the point I was trying to make earlier on.

The CHAIR: You were going to talk about individual advocacy and systemic advocacy, so this might be a good place for you to do that.

Ms Colvin: Yes, it leads into systemic advocacy. You have other bodies where they do inspections, but they go in every three years, for example, and they do spend some months in there. But particularly with children, you have to get good engagement, and that is quite tricky to do. It is quite tricky to do, frankly, with anybody in the mental health space. We have the advantage that, in terms of comparing with staff on the wards, they know that we promote ourselves as being on their side; we are their spokesperson. We have this pure advocacy model, which is that we are speaking up for them and acting on their wishes. For children under 18 it is slightly different, I have to say, because of the act requirements. From that perspective and the fact that we are there on the ground, you can see the issues, which means you do not have to wait until the next three years' inspection, for example. It means that you are getting things that you may not get when you go in for three months and leave again. I am a very strong believer that it is a good thing for a body to do both. I know there are arguments against it, but I argue very strongly for it.

The CHAIR: As I said at the opening, we are very interested in that. I think your views probably coincide quite closely with the commissioner's—that they are intimately linked.

Ms Colvin: Yes.

The CHAIR: And even if they are not done by the same agency, there needs to be a lot of transparency between the two functions.

Ms Colvin: Yes.

The CHAIR: What about accessibility to children? I think you have covered that, because you talked about the —

Ms Colvin: Yes. You will be aware, because we have the ministerial direction on voluntary children, that that was just huge. That followed some reports we did to the minister and so on. That was just a must. There are some tweaking-type amendments to the act at the moment, and I am hopeful it will actually get put into the legislation as well. So it is just —

The CHAIR: Which improves accessibility?

[1.40 pm]

Ms Colvin: Yes. There are obviously still children who are missing advocacy from us in the mental health space and, as I have mentioned, in prisons it is really very limited.

At the moment, the voluntary children have to have been made an inpatient at some stage, basically. I could not say right now that I think we should be an advocate for everybody with a mental health issue, because it is just too broad—we would not be able to cope. We can help children in the community if they have been an inpatient previously and we have assisted them in the previous six months. It is part of the transitioning-out type thinking; that is why we pick up that area. Children in regional areas is an issue for us too, because our youth advocates are in the city.

The CHAIR: I think that is one of the dot points—"Regional and local representation".

Ms Colvin: Yes, it is too.

The CHAIR: I was wondering about your advocacy system in the Kimberley and the Pilbara, for instance.

Ms Colvin: Youth advocates consult by phone with the advocates we have who are placed in Broome, Kalgoorlie, Albany and Bunbury. That is how it works. In the Kimberley, it would be Broome. I think it is still advantageous, because a lot of the issues you hit with children are around processes, what is available, dealing with other bodies like the Department of Communities and that sort of thing. The other thing, of course, is that there are no youth wards in those facilities. They are pretty well all brought down to Perth anyway. A lot of the advocacy at that point in time is getting the Royal Flying Doctor Service in as soon as you possibly can. The Kalgoorlie case that we went in and did a major report on was largely driven by children and young people. We had done a report prior to that—not as big—which was to do with the fact that they were children and they tend to give them ketamine to sedate them while they wait. We saw in the Kalgoorlie case, ketamine was not used. I am not saying it should have been, but you can also see that these places are not safe for children to be kept while they are awaiting care to be flown to Perth and so on.

The CHAIR: If they are not using ketamine, does that mean they are using physical restraint rather than chemical restraint?

Ms Colvin: They do use physical restraint. It will vary. A lot of it is around the physical space itself as to whether or not you can contain a person. That was part of the issue at Kalgoorlie as well.

The CHAIR: You would not have a youth advocate on site. You would have somebody on the phone. You would have an advocate with them, but they would be taking advice on the phone.

Ms Colvin: Yes, and a youth advocate back here in Perth. I have to tell you we have trouble getting advocates in those regions anyway, let alone a youth advocate. It is very hard to get people.

The CHAIR: It is worth you addressing the final dot point, which is "Access to research and statistics relevant to children". This is a major thing, obviously, data sharing.

Ms Colvin: Yes. All we really have is data on children that we assist. I did come prepared to tell you how many involuntary kids there have been so far, if you want that information.

The CHAIR: Yes, that would be interesting.

Ms Colvin: There has been an increase this year in comparison to last year.

The CHAIR: We saw in your annual report there was an indication of that.

Ms Colvin: Yes. I will come back to that in a minute. I know in some of the other areas you talk about seclusion and restraint. We do not have that data. We are increasingly being invited onto various committees and things like that, but we are limited in what we can ask for. In terms of access to research and statistics relevant to children, we could do a lot better in that space. Part of it is us asking for it. Part of it is us having some limitations on what we can ask for. Eating disorders is another area that is dear to our heart with children. Dealing with WAEDOCS for example, we get information that way. Remembering we are not clinicians; we are advocates. With the data —

The CHAIR: We notice in your annual report, you talk about the Kath French centre, which is of great interest to us. You also talk about people waiting days for hospital beds and being admitted to adult wards.

Ms Colvin: Yes. I think we need a little bit longer to be able to answer this definitively. Instinctively, I think it has slightly improved, because we now have two youth wards plus PCH. Basically, when we got PCH—Perth Children's Hospital—it meant we had a few more beds. There are no beds today. I get a bed report every day. There are no beds today. We are dealing with about four or five children waiting this morning. Some of those will be discharged. We have a number of them on 1As, some of them are voluntary. Yesterday was what we call a "code yellow" across the board. A code yellow means there are 15 or more people, which can include children—they do not distinguish—whom we cannot find a bed for. That is when they call a code yellow. The code yellow is off today. We are back to 13 today. Sometimes we get what we call a kids crisis, because we have no beds for kids. It is a snapshot in time every morning. If I look at the bed report, Fiona Stanley never seems to have a bed available. EMYU hardly ever. PCH might have one or two what they call open beds available, but the others are always full. I do not know what the occupancy is at the moment. Tim Marney has told me he is watching that data. I think it has possibly improved slightly, particularly if you then consider that our involuntary orders are going up. This is only to the end of January. To the end of January—this includes people on a CTO; but to compare—we had 58 orders altogether, in comparison to the same time last year when we had only 41 orders altogether.

The CHAIR: Do you know how many of those would be children?

Ms Colvin: That is the children.

The CHAIR: That is all children.

Ms Colvin: Yes. I do not know if you have a handout, but I did bring you in a few copies.

The CHAIR: That would be great; you can table them.

Ms Colvin: It sort of gives you a bit of a thing at the bottom. I could prepare it better for you, but I only thought about this at the last minute that I could actually hand it up to you. You might want me to send it through separately, perhaps.

Hon DONNA FARAGHER: Would it be better that we ask for it on notice and then allow you to then send the copy that you would prefer to actually present to us?

Ms Colvin: Yes, it might be.

The CHAIR: That is fine. Do you want to not give us this now?

Ms Colvin: Maybe do it that way, because that document does not have a header properly on it or anything.

The CHAIR: That is fine. I imagine we will have a few follow-up questions for you anyway, so if you could provide us with that, that would be interesting. That increase is from 40 —

Ms Colvin: This is total orders. It went from 41 orders to 58 orders. This is just in seven months, from July to January. What we are doing here is comparing July to January this year with July to January last year. The other thing that is sort of interesting about some of this is where they are. A person on a 6A is in a mental health ward; a person on a 6B is in a general ward. 6Bs have generally, as I said, tried to commit suicide and have some physical repercussion from that, or they are an eating disorder patient and they are medically compromised. In terms of our 6As, they have gone up in the same period from 21 to 29, and our 6Bs, 12 up to 17. We are seeing an increase in 6Bs—people on general wards across the board, not just in children but in general.

The CHAIR: Do all these cases automatically trigger your oversight mechanism?

Ms Colvin: We get notified and it triggers us going in and making contact with them; yes, that is right. The number of children being put on involuntary orders is increasing. The number of adults is actually, for the first time in three and a half years in, starting to stagnate—stay the same—whereas it had been continually going up, but children are still going up.

The CHAIR: Has that increase been happening for children and young people over a period of years?

Ms Colvin: I, of course, only have data since we started.

The CHAIR: This will be only your third year, would it not?

Ms Colvin: Yes; I cannot say beyond that, but yes, since we have started it has gone up.

The CHAIR: We will take that as a follow-up question on notice if we could, for you to put that data together for us so that we can have a good look at it. That would be good.

Thank you very much for that. That was very illuminating. I am going to ask you whether you would be prepared for us to write to you with some further questions —

Ms Colvin: Yes, certainly.

The CHAIR: — that we are not going to have time to follow up here.

Ms Colvin: I have just noticed the time; sorry.

[1.50 pm]

The CHAIR: But I did want to ask you to comment on—the commissioner's oversight report, first of all, made some recommendations. Are you aware of how those recommendations have been received by agencies such as yours? When you read the commissioner's report, I guess nothing was a surprise to you.

Ms Colvin: No.

The CHAIR: Have you been able to act on any of those recommendations?

Ms Colvin: The major one, I suppose, is the fact that we are now doing some voluntary children; we now have jurisdiction over some voluntary children. That was probably one of the things—what

have we got here: “Strategies for strengthening independent oversight” and so on. “The proactive engagement of independent advocacy with voluntary patients” was one of them, so that has been implemented. It is still limited, but it has been implemented.

The CHAIR: I think you indicated there was some more change in the pipeline.

Ms Colvin: Only in the sense that at the moment it is a ministerial direction, which can of course be revoked at any time; whereas, I am hopeful I am going to get it in the legislation. The other one I am pitching for in the tweaking legislation—because the whole act gets reviewed after five years—is that I have to be notified of any child put on an adult ward. That has not been approved by the minister yet—he has not seen it yet—but that is one of the things that I am pushing for, and I believe the Mental Health Commission is supporting me on this.

The CHAIR: Your relationship with the other oversight agencies—we talked about the Commissioner for Children and Young People; what about the Ombudsman and HADSCO?

Ms Colvin: I have very little to do with the Ombudsman. The Inspector of Custodial Services, every now and then we will talk about issues. We do not have regular meetings, but I have known him for some years. His most recent report about people with a mental illness not being able to get a bed, that started with a terrible story about a woman—not a child—who was brought in in the back of a paddy wagon, naked, from the prison and so on and we —

The CHAIR: Yes. We have actually had a hearing with OICS and they spoke about that.

Ms Colvin: We are involved in that. There was another one later, which was a young person as well. We had a bit of involvement with him around that space. I got responses back from Corrective Services, but basically passing it into his investigation.

The CHAIR: And HADSCO would be one of the other agencies that work alongside you?

Ms Colvin: We get on well with HADSCO and we have been very strong on trying to get complaints process guidelines going. They are almost, almost, almost there. The problem for HADSCO is that they are too far down the track for anybody to complain to. Basically, if you have a complaint, they will tell you to go to the service provider first. By the time you get to the end of that, most people are exhausted, frankly. They are a bit limited on their conciliation and they rarely ever do investigations. I got them to do one a few years ago. I do not think I have had any involvement with them on children—it would be rare. We tend to solve problems before you get to that point, I suppose. Victoria has a complaints commissioner for mental health. It is not the same here with HADSCO.

The CHAIR: Just to finish, can I ask you about the recommendations from the royal commission. You have obviously been through the recommendations, I would imagine, as an oversight agency yourself. Do you see a role for your service in implementing some of those recommendations, particularly as far as oversight goes, recognising that oversight includes those functions like individual and systemic advocacy, inspections, reporting and auditing?

Ms Colvin: I would see a role for us. If we are talking here about really going beyond mental health wards, because in the mental health wards themselves, it is quite limited. Certainly, we have mentioned the Kath French space. I believe there are other places out there where children are basically—“detained” may be too strong a word, but they have got nowhere else to go. I think given that we have the model with the youth advocate, which is a person who has to have experience or training in the area, in that sense we are well placed to expand into those sorts of areas, or at least our model is. Your other problem is that if you are going to bring in multiple models it all gets a bit confused too. I guess the answer would be, yes. I would like to see something like us in the prisons as well, because although the Inspector of Custodial Services has visitors, they are voluntary people.

I do not know much about them, but again it is that youth advocate role—somebody who is really trained in dealing with and talking to children. I do not know if they have any training and I do not know what their visitors do with what they find out. I know they are in there.

The CHAIR: We have interrogated them quite a lot.

Ms Colvin: I never hear anything about them so I would like to see more work done at that level in there. Our youth advocates will pull things together. We do briefings to ministers. I took one of our youth advocates yesterday into a meeting with the minister for disabilities, Stephen Dawson, because we have got real issues. We have had a child with autism—three cases actually—where we are using our mental health wards as basically the providers of last resort. There are some issues around that, which is not good for those children and not good for the other children on the wards and so on. He has asked us to do the case studies for him and give him more details. It is that sort of work you really want to get into.

The CHAIR: That has been very interesting. Somewhat reluctantly, I am going to close the hearing. That was very interesting. Thank you.

Ms Colvin: It was a pleasure to be of help. Yes, by all means, I will get those to you. I will wait then perhaps —

The CHAIR: What we might do is go through the questions that we prepared for you. I think you have covered an enormous amount of material in the 55 minutes that we have been talking. We will see if there is anything that jumps out as needing further information from you and then we will contact you with that.

A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary document for the committee's consideration when you return your corrected transcript of evidence.

Thanks very much for your time this afternoon. I really appreciate that.

Hearing concluded at 1.56 pm

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